College of Nurses of Ontario
Ordre des infirmières et infirmiers de l'Ontario

THE STANDARD OF CARE.

Test yourself
Documentation

Evaluate your knowledge of the College of Nurses of Ontario's (CNO's) *Documentation* practice document with the following test questions.

Participation in this quiz is self-directed and anonymous. CNO does not collect individual quiz scores or answers. *(Answers are on page 4)*

Question #1

A nurse teaches a client how to self-administer insulin. What should the nurse document in the client's health record?

A. the information provided to the client

B. the client's comprehension of the information

C. the client's ability to administer the insulin

D. all of the above

Question #2

The client tells the nurse, "I've never had surgery before and I'm sort of nervous about it." The nurse documents the client's statement in his chart. The client's statement is an example of

A. objective data

B. subjective data

C. third party reporting

Question #3

A nurse has just started a new role at a new facility. As she reviews the employer's documentation policy, she notices that it does not follow CNO's *Documentation, Revised 2008* practice document. The nurse should

A. disregard the new employer's policy and follow the policy of her old employer

B. disregard the employer's policy and follow the clinical instruction provided in her nursing program

C. raise her concerns with her new employer and advocate for changes to the organizations policy

D. follow the employer's policy because it is the most applicable to that practice setting

Question #4

It is solely the employer's responsibility to identify the systems problems that may have an impact on a quality practice setting.

A. True

B. False

Question #5

When correcting an error in documentation a nurse should

A. also correct any errors made by other nurses

B. correct the error, leaving the original entry visible and sign the entry

C. permanently erase the error

Question #6

A nurse practising in the community takes temporary notes on relevant client information. When he returns to the office, he enters the information into the clients permanent health record. What should he do with the temporary documentation?

A. He should not use temporary documentation.

B. He should ensure the temporary documentation is destroyed in a secure way, such as shredding.

C. He should file the temporary documentation for later retrieval.

Question #7

Client care may be at risk when documentation systems that support information sharing and decision making within the circle of care are not in place.

A. True

B. False

Question #8

A nurse working in an immunization clinic is required to save client data on a portable electronic device and later take the device to her employer's office. Which of the following is the most important factor to safeguard client data?

A. Encrypt the information being stored on the device.

B. Store the device in a locked area until she is ready to take it to the office.

C. Keep the information password-protected.

Question #9

Under what circumstances is a nurse permitted to document for other members of the health care team?

A. when working as a team

B. when working with an unregulated care provider

C. when the nurse has been designated the recorder

D. when a coworker has forgotten entry and is off shift

Question #10

A registered practical nurse RPN, has recently obtained a baccalaureate degree in business administration BBA. When signing documentation, what should her signature include to meet CNO requirements?

A. RPN, BBA

B. BBA, RPN

C. RPN

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Answers with rationale

ANSWERS

Question #1
Options A, B & C are all correct; therefore, the **right answer is D,** all of the above.

Question #2
Option B is correct.

Option A is incorrect.
Objective data includes data that can be observed and measured, such as blood pressure.

Option C is incorrect.
Third party information comes from a person other than the client or member of the circle of care.

Question #3
Option C is correct.

Option A is incorrect.
The policy of her former employer won't be applicable to her new practice setting. The nurse needs to advocate to her new employer to modify the policy to follow the documentation practice document.

Option B is incorrect.
The instruction from her nursing program won't be applicable to her new practice setting. The nurse needs to advocate to her new employer to modify the policy to follow the documentation practice document.

Option D is incorrect.
The policy is the most applicable to the practice setting, the nurse needs to advocate to her new employer to modify the policy to follow the documentation practice document.

Question #4.
Option B is correct.

Option A is incorrect.
It is the responsibility of the employer and members of the health care team to identify systems problems.

Question #5
Option B is correct.

Option A is incorrect.
The nurse should never alter another nurse's documentation.

Option C is incorrect.
All documentation, even errors, must remain visible or retrievable.

Question #6
Option B is correct.

Option A is incorrect.
Temporary documentation is permissible, as long as the information is transferred to the clients permanent health record and the temporary documents are destroyed securely.

Option C is incorrect.
Once the information has been entered into the client's permanent health record, the temporary documentation should be destroyed securely.

Question #7
Option A is correct.

Option B is incorrect.
One of the main purposes of documentation is to support communication and decision-making within the circle of care.

Question 8
Option A is correct.

Option B is incorrect.
Keeping a device in a locked area doesn't protect the personal health information stored on the device if it is stolen or lost.

Option C is incorrect.
A password can be bypassed, allowing others to access the personal health information stored on the device.

Question #9

Option C is correct.

Option A is incorrect.

The only time a nurse should document for another member of the health care team is when that nurse has been designated the recorder, such as in an emergency situation.

Option B is incorrect.

An unregulated care provider should document the care that they provide.

Option D is incorrect.

Documentation should be completed by the individual who provided the care, unless it is an emergency situation.

Question #10

Option C is correct.

Option A is incorrect.

CNO requires only the nurse's designation to be included with the signature.

Option B is incorrect.

CNO requires only the nurse's designation to be included with the signature.